VERMONT COMMUNITY HOSPITALS UNCOMPENSATED CARE POLICIES

BISHCA FINDINGS AND RECOMMENDATIONS

TO

THE HOUSE COMMITTEE ON HEALTH CARE, THE SENATE HEALTH AND WELFARE COMMITTEE, AND THE SENATE FINANCE COMMITTEE

JANUARY 2007

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The Department of Banking, Insurance, Securities & Health Care Administration would like to thank the Vermont community hospitals, the Vermont Association of Hospitals and Health Systems, the Joint Fiscal Office, Blue Cross/Blue Shield, CIGNA, MVP, the State Health Care Ombudsman, and public participants Craig Fuller and Greg Peters for their commitment of time, energy and intellect in reviewing this report.

Executive Summary

The Uncompensated Care report is required by Act 191 to recommend a standard statewide uniform uncompensated care and bad debt policy. The report also requires the Department of Banking, Insurance, Securities, and Health Care Administration to determine a fair and thorough method for calculating and reporting information about uncompensated care and bad debt to ensure accurate accounting in the hospital budgets and other health care facility planning, as well as collecting information about the types of patients accessing uncompensated care or who are unable to pay for the care received.

The Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) met several times with hospitals to discuss critical issues and the preparation of this report. Upon preparation of the draft report, BISHCA shared a draft with insurers, consumers, the State Health Care Ombudsman, and each individual hospital. The recommendations included in this report are being delivered to the Senate committees on Health and Welfare and Finance and the House committee on Health Care in January 2007.

BISHCA identified both opportunities and limitations while preparing its report. All hospitals have a written uncompensated care policy that addresses who is eligible, how to become eligible, what services are eligible, and many other considerations that must be addressed. Though some of the standards differ across hospitals, there are legal and local circumstances that explain or support a differing standard. In addition, there are other considerations that require a better understanding by BISHCA before an objective standard can be established.

It is clear that BISHCA can obtain good information about the uncompensated care populations that use these services that will prove helpful in trying to establish cost and program needs for the under-insured and uninsured. To better understand what information is available and the cost/benefit of trying to obtain this information, BISHCA will establish a timeline and process to work with the report participants.

In summary, BISHCA found that written policies exist across the Vermont hospital system, minimum standards exist for criteria around residency and income level and an application process exists for qualifying for free care. While all standards are not the same, our findings suggest that they are reasonable at this time. We will establish a process for examining these standards more thoroughly as well as address the specific data elements that can be collected about the bad debt and free care populations. Some of these data will be more easily collected than others and could very well depend upon hospital information systems. All of this will be reviewed with the objective of providing fair, accurate, and reasonable reporting requirements. The recommendations in this report contain the plans and considerations that BISHCA will address over the next several months.

Background

Section 29 and 30 of Act 191, An Act Relating to the Health Care Affordability for Vermonters, enacted during the 2006 legislative session, requires that BISHCA "...in consultation with representatives of the Vermont association of hospitals and health systems, third-party payers, and health care consumers, shall review the uncompensated care and bad debt policies of Vermont's hospitals and recommend a standard statewide uniform uncompensated care and bad debt policy." A report including the recommendations is to be filed with "….the senate committees on health and welfare and on finance and the house committee on health care not later than January 15, 2007." (The complete text of Section 29 –30 is provided in Appendix A.)

The statute dictates four basic actions:

1) That BISHCA review the uncompensated care and bad debt policies of the hospitals,

2) That BISHCA recommend a standard policy to include:
   i. Criteria for payment forgiveness for health care services received by low income patients,
   ii. Criteria for a sliding scale payment for patients under certain income limits,
   iii. A method for calculating services received,
   iv. And other criteria to ensure that the care received by the uninsured and underinsured is billed in a uniform and consistent manner.
   v. In addition to the above, the Commissioner may recommend methods or other standards that provide for deviation in the policy for hospitals with unique circumstances.

3) That BISHCA determine a fair and consistent method for calculating and reporting uncompensated care information in the hospital budgets, and

4) That BISHCA collect information about the types of patients, the patient's primary insurance status, employer, the cost of care received, amounts paid for care, and the discount provided.

What is uncompensated care?

The hospital community has traditionally used the term "uncompensated care" to refer to bad debt and free care (or charity care). According to the American Hospital Association, the term uncompensated care excludes other unfunded costs of care such as the underpayment from Medicare and Medicaid.[1] Bad debt comes from care for which payment is expected, but the hospital cannot collect because the patient refuses to pay. Free care is distinguished from bad debt in that it has been determined that the patient cannot afford to pay and therefore the hospital does not expect payment. BISHCA uses

[1] American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet", October 2006

similar definitions to describe these terms in its annual budget instructions to the hospitals in the Vermont Community Hospitals Uniform Reporting Manual. (see Appendix B)

The importance of reporting hospital uncompensated care

The importance of reporting uncompensated care has long been recognized in Vermont as part of its budget reporting process. The Vermont Hospital Data Council established the need for that reporting as far back as 1984 when the budget review process was started. Uncompensated care is one of the factors in the budget reviews that are considered when evaluating hospital rate requests.

However, historically, hospitals had different reporting policies and thus comparing bad debt and free care across hospitals was sometimes misleading. This problem was recognized by the American Institute of Certified Public Accountants (AICPA) that addressed the importance of reporting uncompensated care correctly in an updated audit guide issued in 1996.[2] Besides describing the need for accounting for bad debt and free care in a standard manner, the guide also stated it was necessary to distinguish between each of these because they reveal different information. Both free care and bad debt represent uncompensated resources that must be managed to plan for the institution's financial health. Free care represents the scope of the institution's charitable care policy while bad debt is an important measure of risk for the institution's revenue cycle.

And finally, the importance of this information has been raised through the numerous cost reform efforts across the country that is trying to address the underinsured and the uninsured. Besides the new law in Act 191 of the Vermont legislature, the most recent Health Finance Management Association (HFMA) publication (January 2007) described the need for policymakers, community groups, rating agencies, and hospitals to require better and more complete information on uncompensated care in order to address a variety of reform matters.[3]

Vermont Community Hospitals

Free care

Today, all Vermont hospitals have prepared written uncompensated care policies. The current policies address a variety of issues to provide consistent and objective information. For example, the valuation of free care is established through each hospital's accounting practices and the policies used by the hospital to guide eligibility and any related discounting. However, the policies for each hospital were developed with limited guiding principles.

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[2] Healthcare Financial Management Association Principle and Practices Board; Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers

[3] Healthcare Financial Management Association, "From the President", January 2007, p. 176

BISHCA, as part of the annual hospital budget review process, has recommended that hospitals establish a basic policy of providing free care to those at 200% of the federal poverty level (Appendix B). However, the recommendation has not been binding and did not suggest any qualifying standards such as residence or assets as part of the test for determining one's scope of eligibility. BISHCA's review of the hospitals' policies finds that all Vermont hospitals provide for free care, although there are differences in their individual policies.[4]

Strict standards for all hospitals were never implemented by BISHCA out of deference to local board control and in recognition of the differences in demographics and wealth across the various hospital communities. Just as budgets are independently prepared and considered by local hospital boards, so are the policies establishing who should have access and how those services are paid. The Healthcare Financial Management Association (HFMA) also disagrees with the concept that "one size fits all". As stated in HFMA's Statement 15, "No single set of criteria for charity care policies is universally applicable".[5]

BISHCA completed a survey and review of the various criteria that the HFMA Principle and Practices Board recommends in Statement 15. A description of the criteria is listed in Appendix C. In addition, a lot of useful information for helping hospitals to manage free care patients can be found at the HFMA and AHA sponsored PATIENT FRIENDLY BILLING PROJECT web site.[6] A copy of the letter from those organizations describing the project can be found in Appendix D.

Upon review of the uncompensated care policies that the hospitals have submitted, BISHCA found the following consistencies (see Appendix G):

1) The residence criteria for establishing eligibility are based upon, at a minimum, the hospital's defined Hospital Service Area. Some hospitals provide an even broader geographic and/or residence criteria.

2) All hospitals require an application to be completed providing income verification. The scope of requirement is different across hospitals and some also require asset information.

3) All hospitals use the federal poverty guidelines (Federal Poverty Level, or FPL) established by the Department of Health and Human Services[7] for measuring income eligibility.

[4] All Vermont hospitals have a written free care policy and each is provided in hard copy when requested. Some hospitals post their policies on their web sites.
[5] Healthcare Financial Management Association Principle and Practices Board; Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers
[6] www.patientfriendlybilling.org
[7] United States Department of Health and Human Services web site; http://aspe.hhs.gov/poverty/06poverty.shtml

4) For eligible patients whose income was at 100% of the FPL, every hospital provided 100% discounting for those patients. Only two hospitals are below 200% of the FPL.

5) All hospitals provide a sliding scale for patients exceeding the 100% discount guideline. The amount of the discount differs across hospitals for different income levels.

Besides these criteria, the Vermont hospital policies include methods for handling the following:

1) Policies that address whether discounts may vary if the cost of the service is high relative to the patient's income,

2) Polices address the time frame for allowing the eligibility needs to be established,

3) Policies address how often patient eligibility must be re-evaluated, as well as how the policy will be disclosed,

4) Policies are written to comply with Federal and/or state law,

5) Policies address how patients can get help such as individual counseling.

These unique circumstances and suggested new reporting requirements will require more work and discussion with the Vermont hospitals and others to determine if existing standards are adequate. BISHCA believes it is important to understand all the differences in data collection and policy determinations before establishing any final standards.

Bad debt expenses

Bad debt, as reported on the Profit & Loss statement, is a combination of actual accounts recognized as bad debt and the anticipated bad debt expense (reserve) within the accounts receivable for a given period. This reserve is estimated based on aging, payer mix, and service mix in the receivable at the end of that period. Independent accounting firms review the bad debt estimates as part of their annual audit for the hospital and will recommend adjustments if the hospital is too conservative or not conservative enough in estimating the expense. This is part of the AICPA accounting policy that tries to ensure that revenues and expenses are appropriately recorded in a timely manner. The hospital's actual audit financials report bad debt as an expense while the hospital budget reporting through BISHCA requires it to be recorded as a deduction from revenue. This is just a

difference in classification and it does not affect the end result of the financial statements.[8]

Bad debt is recommended to be recorded at the amount of the actual charge (gross revenue). The actual costs are recognized (gross charges less overall contractual %) for partial reimbursement by Medicare. This reimbursement from Medicare has been reduced over the years depending on the hospital Medicare classification but does reduce the cost-shift slightly. Because bad debt is defined by those able, but unwilling to pay, free care policies don't directly address the criteria for "qualifying." Rather, this is an accounting mechanism used to record such events and for establishing policy for recording and managing the possible collection of balances due.

What information is currently available?

Vermont hospitals are required to file a proposed budget for the forthcoming fiscal year that includes financial information, scope-of-service and volume-of-service information, utilization information, proposed new services and programs, capital depreciation and expenditure plans, and any other information the Commissioner may require. (18 V.S.A. § 9454) BISHCA conducts reviews of the submitted hospital budgets along with other information, and the Commissioner establishes a budget for each hospital within which each hospital shall operate. (18 V.S.A. § 9456)

The bad debt and free care information reported by the hospitals is defined in the Vermont Community Hospitals Uniform Reporting Manual. (see Appendix B) The real distinction between bad debt and free care is that free care is recognized as care provided to those who **do not have the ability to pay** (as documented) while bad debt is considered amounts of care received by those who **can pay but have failed to do so or those that have failed to apply for free care**. The bad debt category is also distinguished from free care in that patients included in bad debt could include those who have insurance. Disputes over the care received or coverage expectations are other examples of bad debt expense, though it is uncertain how often these occur.

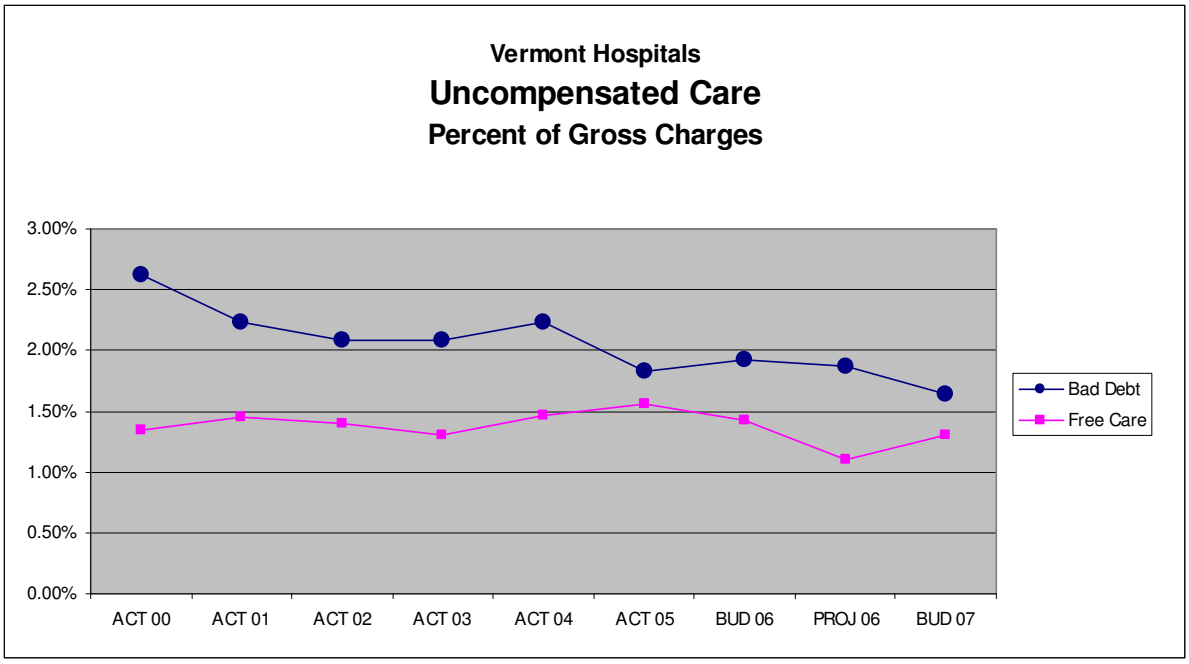
The chart below reflects the hospital system trend of bad debt and free care for all the hospitals from 2000 to 2007. The calculated values are based upon actual information submitted by the hospitals through the budget review process. As you can see, the combined bad debt and free care percent of gross revenues has gone from 3.9% in 2000 to just under 3% in budgeted 2007. The decrease is primarily related to a reduction in overall bad debts as they relate to gross revenues. This information can be further examined by reviewing each individual hospital trend through this period.

The detail for each hospital and the bad debt and free care trends are published by BISHCA as part of its annual budget reviews. The information is published annually in

[8] It should be noted that while BISHCA does present the bad debt and free care in a different manner than suggested by the AICPA Audit Guide, the measure of its value and the effect on the financial statements are the same.

the *Vermont Community Hospitals – Financial and Statistical Reports*. Some of the key data trends and comparisons are outlined below in the **Findings** section of this report.

(see http://www.bishca.state.vt.us/HcaDiv/Data_Reports/a_data_reports_index.htm)



Findings

BISHCA has always examined reported bad debt and free care information from the hospitals as part of its annual budget reviews. Part of the reviews includes an analysis of change from year to year in those categories to ensure they are reasonable. BISHCA has identified the following financial facts for the period 2000 through 2007:

1) In relative terms, bad debt has decreased. As a percent of gross revenues, bad debt in FY 2007 is budgeted at 1.6%. This is lower than the 2.6% amount in FY 2000. The national trend in recent years has been an increase in bad debt write-offs.

2) In relative terms, free care has remained the same. As a percent of gross revenues, free care in FY 2007 is budgeted at 1.3%. This is the same amount as occurred in FY 2000.

3) Bad debt for Vermont hospitals is budgeted at $41.8 million in charges for FY 2007. Although bad debt is a lower percent of overall gross revenues

in FY 2007 when compared to FY 2000, this is a 26% increase over the actual amount of $33.1 million in FY 2000.

4) Bad debt in FY 2007 is estimated at $23.8 million.

5) Free care for Vermont hospitals is budgeted at $33.2 million in charges for FY 2007. Although free care is the same relative percent of overall gross revenues in FY 2007as in FY 2000, this is a 96% increase over the actual amount of $16.9 million in FY 2000.

6) Free care in FY 2007 is estimated at $18.9 million.

7) In FY 2007, bad debt, as a percentage of gross revenue, ranges from a low of 0.8% at Grace Cottage to a high of 3.5% at Porter Medical Center. Free care ranges from a low of 0.8% at Grace Cottage to a high of 2.6% at Springfield Hospital.

8) Ten of the fourteen hospitals have seen a relative decrease in their bad debt since 2000. Eight hospitals have seen an increase in the relative amount of their free care.

9) Certain demographic data could be collected in this year's hospital budget review process.

10) Selected free care policy standards and data will require a more thorough review before final standards can be established.

BISHCA has also gathered each hospital's current uncompensated care policy and reviewed it against some of the criteria listed in Appendix C derived from the recommendations of the Healthcare Financial Management Association Statement 15. BISHCA has identified the following practices across the hospitals:

1) **Residence** – Many hospitals establish geographic boundaries as to whom may be eligible for free care at the hospital. Quite often this is established as the service area of the hospital. The hospital service area (HSA) is currently defined by each hospital based on its own market analysis.

2) **Service limitations –** Most hospitals have outlined a policy that no assistance will be provided for non-medially necessary or non-urgent types of services (cosmetic, infertility, etc.).

3) **Payment forgiveness criteria** – All hospitals have certain filing requirements for:

Income/asset verification – Each patient is expected to apply for free care in order to receive any discounting. Various financial forms are required

depending upon the hospital. Some hospitals also require verification of other assets the patient may own.

Application for other benefits - Each patient is expected to apply for all other forms of possible reimbursement to which the patient may have access. Programs that might be applied for include Medicaid, Medicare, Veterans benefits, etc.

4) **Payment forgiveness scope** – Hospital policies differ in degree in part due to local economic and cultural issues and their financial capacity. Each has plans that address:

Amount of payment forgiveness

100% free care discount – Each hospital has established a maximum level of income up to which they will provide 100% free care. The lowest maximum is at 100% of the federal poverty level (FPL).

Sliding scale free care discount – Most hospitals have established some type of sliding scale based upon income and other criteria. The scale begins where the 100% discount policy ends.

Recommendations

BISHCA finds that hospitals' formal uncompensated care policies are quite thorough and include various application forms, details for scheduling payments, and exception policies that try to address a variety of circumstances that are currently beyond the scope of this review. Some of the policy detail is also written to ensure compliance with Medicare and Medicaid law. BISHCA needs to better understand the differences in the policies and whether they are driven by legal needs or other circumstances.

BISHCA has collected and reviewed various sources about bad debt and free care policies as part of this effort. In addition, the Healthcare Financial Management Association recently published Statement 15 establishes standards for hospital charity care and bad debt reporting and analysis. Using this research, as well as consultation with insurers, consumers, the State Health Care Ombudsman, and the Vermont hospitals, BISHCA has prepared recommendations which include the need to use the existing budget review process to establish and communicate standards, the need to establish some new reporting requirements, and a process for identifying and collecting that information. These recommendations are:

1) **Establish a process to review standards and data requirements.**

a) BISHCA will work with the hospitals, insurers, the State Health Care Ombudsman, and consumers to develop a timeline and

reporting structure for establishing standard policies and collecting new data.

2) Establish a standard policy.

The statute requires the Commissioner to establish a "…standard statewide uniform uncompensated care and bad debt policy." The statute also provides for some discretion by the Commissioner to allow for deviations in the policy due to circumstances that may warrant that need.

a) BISHCA will update its policy and procedures in the Vermont Community Hospitals Uniform Reporting Manual to establish the uniform standard reporting requirements to be used in the hospital FY 2009 budget review process.[9]

b) BISHCA will request information through the FY 2008 budget review process to address outstanding information needs and policy considerations found in this report.

c) BISHCA will further research the accounting standards and invoicing procedures around bed debt and free care so as to ensure that they are consistent across the hospitals.

d) The uniform standards will require all hospital free care policies to include criteria that define minimum expectations as to:

1. The poverty level at which 100% bill forgiveness will be required,
2. The residency requirements that a patient must meet to apply for free care or discounted care,
3. Whether certain types of health care services should be limited or restricted,
4. The scope of income and/or asset requirements that must be met,
5. Consideration of a standard application form that will meet all hospital needs for legal and unique policy requirements,
6. The grievance and appeal processes,
7. The locations where hospital free care policies should be posted and/or available for patients,
8. And establishment of the best method of calculating the services received by patients.

[9] The Vermont Community Hospitals Uniform Reporting Manual provides the budget instructions and reporting requirements for community hospitals as part of the annual hospital budget reviews.

3) Examine new reporting requirements

In addition to requiring standards for the eligibility, financial accounting, and recording of uncompensated care services, Act 191 asked BISHCA to consider whether collecting additional information about free care is necessary (see Appendix A, Section 30 b). Discussion with the hospitals found that while many hospitals already capture selected portions of these data, there are few standards and definitions to allow for the data to be consistent.

a) Data elements to be considered for collection include:

1) the count of individual cases for both bad debt and free care,

2) an unduplicated count of the number of patients,

3) the number of patients who are employed,

4) the number of patients who have some other kind of insurance coverage,

5) the age of the patients and whether they are male or female,

6) the total invoiced amount per event, the discount, and the cost of that service, and,

7) other information that may be considered necessary to appropriately inform the legislature and the budget process about uncompensated care.

b) The new reporting requirements will go into effect no later than the FY 2009 annual hospital budget review process.

Appendices

Appendix A: Act 191 Uncompensated care legislation

Appendix B: Bad Debt Free care (Uniform Reporting Manual)

Appendix C: Healthcare Financial Management Association Principle and Practices Board; Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers
- Criteria for free care

Appendix D: PATIENT FRIENDLY BILLING PROJECT
- Letter about the project

Appendix E: Vermont hospital financial information

Appendix F: Calculation cost of free care/bad debt

Appendix G: Matrix of hospital current free care standards

Appendix A

ACT 191 UNCOMPENSATED CARE LEGISLATION – 2006

Sec. 29. HOSPITAL UNCOMPENSATED CARE; FINDINGS

(a) The general assembly finds that all of Vermont's community hospitals are nonprofit charity hospitals that provide care regardless of patient ability to pay. Any uncompensated care received is paid for by someone other than the patient receiving it. This uncompensated care is substantial.

(b) Uncompensated care is already being paid for. It is subsidized through the "cost shift" and is absorbed principally by the payers of private health insurance premiums, including self-insurance plans. This cost shift functions as a hidden surcharge for the cost of care to lower income individuals.

Sec. 30. HOSPITAL UNCOMPENSATED CARE; STANDARDS; REPORTING

(a) The commissioner of banking, insurance, securities, and health care administration, in consultation with representatives of the Vermont association of hospitals and health systems, third-party payers, and health care consumers, shall review the uncompensated care and bad debt policies of Vermont's hospitals and recommend a standard statewide uniform uncompensated care and bad debt policy. The standard policy shall include criteria for payment forgiveness for the cost of health services received by low income patients, criteria for a sliding scale payment amount for patients under certain income levels, a method for calculating the amount of services received by the patient, and other criteria necessary for ensuring that the care received by the uninsured and underinsured patients is billed in a uniform and consistent manner. In addition to a standard policy, the commissioner may recommend reasons for and a method of approving deviations from the standard policy by a hospital or may recommend a set of standard policies to be applied to hospitals based on particular criteria, such as a designation as a critical access hospital, the income median in an area, or any other rationale.

(b) The commissioner, in consultation with the representatives listed in subsection (a) of this section, shall determine a fair and thorough method for calculating and reporting information about uncompensated care and bad debt to the department of banking, insurance, securities, and health care administration to ensure accurate accounting in the hospital budgets and other health care facility planning, as well as collecting information about the types of patients accessing uncompensated care or who are unable to pay for the care received. The commissioner shall consider collecting information about the patient receiving the care, including the patient's primary insurance status and employer,

Appendix A (continued)

the actual cost of the care received, any amounts paid toward the care, and any discounts provided to the patient by the hospital.

(c) The commissioner's findings and recommendations shall be submitted in a report to the senate committees on health and welfare and on finance and the house committee on health care not later than January 15, 2007.

Appendix B

BAD DEBT AND FREE CARE REPORTING

Excerpt from Vermont Community Hospitals Uniform Reporting Manual - FY 2007
BUDGET REPORTING PROCEDURES

Glossary

Free Care: This is the term used to recognize the loss of revenues billed and due but not received. It is considered a "free" service because the individual involved is considered to have a limited or no ability to pay.

Bad Debt: This is the recording of an expense for recognizing the loss of services billed and due but not received. It is considered a "bad debt" because the individual is considered to have an ability to pay.

"Deductions from Operating Revenue"

In many instances, the Hospital receives less than its full-established charges for the services it renders. It is essential that reporting information reflect both the gross revenue "adjustments" resulting from inability to collect established charges for the services it renders. These revenue "adjustments" are called Deductions from Revenues and are of the following primary categories:

1. Contractual Adjustments X These adjustments represent the difference between full established charges for individual services and the contractual rates received or to be received from third-party payers for services rendered.

2. Free Care X These deductions represent the difference between full-established charges and amounts received or to be received from indigent patients, voluntary agencies, or governmental units on behalf of specific indigent patients.

3. Bad Debt X These deductions represent the difference between full established charges and amounts received or to be received from those that are able to pay but fail to do so.

4. Employee or Other Discounts X These deductions represent adjustments for items such as courtesy allowances and employee discounts from the Hospital's full established charges for services.

The above items must be recorded and reported as deductions from gross operating revenue on an accrual basis rather than as expenses."

Appendix B (continued)

"Bad debt and free care reporting – All hospitals must report bad debt and charity care as separate, distinct cost centers in the budget submission. Charity care deductions are defined as the difference between gross charges and any subsequent reimbursement that may be received from - or on behalf of – those individuals determined eligible for this "free care". It is recommended by the Health Care Administration (HCA) that all hospitals should adopt a minimum "floor" of eligibility standards for determining who should receive such care. In the absence of any agreed upon minimum at this time, the HCA recommends that individuals whose gross income is at – or less than – 200% of poverty, should be eligible for "free care" (200% of poverty as defined by the Federal Government).

Note: The AICPA ruling includes bad debt as an expense. Until further notice, the Division requires that you report bad debt as a deduction from revenue.

No netting of revenues should occur. All reimbursement received should be reported through gross revenues, deductions and net revenues, as applicable."

Appendix C

Healthcare Financial Management Association Principle and Practices Board; Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers

III. Criteria for Charity Care

3.1 No single set of criteria for charity care policies is universally applicable. Each institutional provider of healthcare services must establish its own policies that are consistent with the organization's mission and financial ability, as well as with state laws. Examples of the wide range of influences on an organization's charity care policy include:

- Some providers have financial resources dedicated to the provision of charity care, such as philanthropy, state or local tax revenues, or designated federal resources.
- Some providers serve wealthy communities, while others are located in areas with many low income residents.
- Some communities support public hospitals with a special mission to serve indigent patients.
- Some institutions provide specialized services that influence their charity care policies.

3.2 Charity care and bad debt policies should be clearly documented and approved by the provider's governing body. The existence and basic eligibility criteria of these policies should be communicated to patients and the community.

3.3 Eligibility criteria for charity care or discounts are often based on a percentage of the federal poverty guidelines (which are set by the Department of Health and Human Services to determine financial eligibility for certain federal programs) or the eligibility guidelines used for Housing and Urban Development programs. States may also have charity care criteria for specific purposes. Providers must be able to identify patients who fulfill these criteria for relevant government programs
(see paragraph 3.7 for discussion of cases where insufficient information for charity care determinations is available). Where state regulations exist, they represent minimum standards, but individual organizations' policies may be broader.

3.4 When determining eligibility for a provider's financial assistance program, a number of factors must be considered, all of which require judgment. Thus, the expectation that criteria can be applied rigidly is unrealistic. By allowing for some flexibility in charity care eligibility standards, providers can avoid rigid or complex programs that are difficult for staff to carry out and for patients to understand. Similarly, criteria may be more detailed and call for more specific evidence of eligibility for large amounts of charity care than for small amounts.

3.5 Eligibility criteria for charity care could include many factors. The following list provides examples, but is not definitive:

3.5(a) Individual or family income, which may take into account family size, geographic area, and other pertinent factors. Individual or family income

Appendix C (continued)

generally is not the exclusive criterion for determining the appropriate amount of charity care.

3.5(b) Individual or family net worth, which considers liquid and nonliquid assets owned, less liabilities and claims against assets. It should be noted that when gathering this information from the patient, it is useful to clarify whether this information will be used solely to determine eligibility or whether the assets would be considered as a possible source of payment.

3.5(c) Employment status criteria should consider the likelihood of future earnings sufficient to meet the healthcare-related obligation within a reasonable period of time.

3.5(d) Other financial obligations, for example, living expenses and other items of a reasonable and necessary nature.

3.5(e) Amount and frequency of healthcare bills, or the potential for medical indigence (sometimes referred to as medical hardship), must be considered in relation to all the other factors outlined above. The history of service and the need for future service by the institution or other providers may be considered. In these cases, a separate determination of the amount of charity care for which a patient is eligible is made on each occasion of service, or regular confirmation of eligibility is made during extended programs of service.

3.5(f) Other financial resources available to the patient, such as Medicaid and other public assistance programs, will affect the determination of the appropriate amount of charity care.

3.6 Different providers may apply similar criteria differently. For example, a patient with catastrophic healthcare costs but with substantial net worth may be eligible for charity care by one provider, but another provider may require net worth in excess of a threshold be used to pay for healthcare services before the patient is eligible for charity care. Some providers may be able to establish automatic criteria for certain classes of patients (such as for noncovered services to Medicaid patients), and other providers may require case-by-case determination.

3.7 Determining the amount of charity care for which a patient is eligible is based in large part on information supplied by the patient or someone acting on the patient's behalf. The charity care policy should address eligibility for charity care when there is insufficient information provided by the patient to fully evaluate all the criteria and the ability to pay cannot be reliably determined. Policies may refer to external sources such as credit reports or Medicaid enrollment to help support such determinations.

3.8 Data used to determine eligibility for charity care should be verified to the extent practical in relation to the amount involved and the significance of an element of information in the overall determination. Similarly, a single element of information may

Appendix C (continued)

be sufficient to make a reasonable determination, and additional investigation would not be cost-effective. The procedures implementing the charity care policy should address the extent of verification necessary and any modification of a determination already made if subsequent findings indicate the information relied upon was in error.

3.9 In gathering information about charity care eligibility, providers should ensure their financial communications and counseling are clear, concise, correct, and considerate of the needs of patients and family members, in accordance with the principles of the **PATIENT FRIENDLY BILLING®** project. (The Patient Friendly Billing project is a nationwide initiative to improve financial communications with patients. For more information, visit www.patientfriendlybilling.org.)

Appendix D

Dear Colleagues,

We are pleased to present this report on the *PATIENT FRIENDLY BILLING®* Project's examination of the issues surrounding discounting and collection practices for patients with limited ability to pay. As increasing numbers of hospitals are updating their financial policies, they find that there are many factors to consider and numerous alternative approaches. Hospital leaders need practical ideas as they revise policies. This project and report were designed to address some of these issues. The *PATIENT FRIENDLY BILLING®* Project worked with hospital system leaders across a broad cross-section of the field to produce this report. We conducted interviews, solicited advice from systems that had recently updated their financial policies for uninsured and underinsured patients, and analyzed alternative approaches to updating policies and procedures.
Each hospital and community has unique considerations. There is no single approach or set of solutions that apply to all hospitals. By addressing the following seven questions, each hospital can develop responsible, balanced policies and practices for their community:

1. Who qualifies for discounted or free care?
2. What services are discounted?
3. What discount levels are offered?
4. How are policies communicated?
5. How are unpaid patient accounts resolved?
6. What structures and systems are in place to implement and administer policies effectively?
7. What is the relevant legal and regulatory context?

Hospitals that have recently revised their policies shared with us lessons learned about characteristics of useful policies; the need to involve others; procedures for training, implementation and monitoring; methods to help patients; and the importance of early action. We hope discussion of these questions and lessons learned encourages hospitals to continually improve their financial policies. Many of the ideas and approaches in this report address symptoms of the bigger issue–45 million Americans without health insurance. These Americans also have difficulty paying for prescription drugs, physician services and other healthcare services. Hospitals need to continue to work with policy makers and others to develop solutions to the underlying issues of increasing numbers of uninsured and underinsured patients. In the meantime, please join our efforts to make an immediate difference in your community by considering ways to improve your financial policies.
We hope the tools and approaches in this report give you specific, practical ideas that work!

Sincerely,
Richard L. Clarke, FHFMA
President & CEO
Healthcare Financial Management Association

Richard J. Davidson
President & CEO
American Hospital Association

Terry Allison Rappuhn
Project Leader
PATIENT FRIENDLY BILLING® Project

Appendix E

Vermont Community Hospitals
Bad Debt & Free Care

Bad Debt	ACT 00	BUD 07	ACT 00	BUD 07
Brattleboro Memorial Hospital	$1,050,159	$1,612,199	3.0%	2.0%
Central Vermont Hospital	$2,983,826	$3,148,493	3.4%	2.1%
Copley Hospital	$1,502,627	$1,474,373	4.8%	2.5%
Fletcher Allen Health Care	$16,059,954	$15,846,147	2.5%	1.2%
Gifford Memorial Hospital	$956,050	$1,163,418	3.1%	2.0%
Grace Cottage Hospital	$113,287	$93,424	1.6%	0.8%
Mt. Ascutney Hospital	$282,104	$968,554	1.2%	1.7%
North Country Hospital	$1,408,460	$2,437,384	3.4%	2.6%
Northeastern Vermont Regional Hos	$1,026,830	$1,525,000	2.7%	2.2%
Northwestern Medical Center	$1,753,481	$1,634,590	3.6%	2.0%
Porter Medical Center	$1,007,671	$2,508,305	2.4%	3.5%
Rutland Regional Medical Center	$2,283,055	$5,528,327	2.0%	2.2%
Southwestern Vermont Medical Cen	$1,779,120	$2,179,541	2.3%	1.5%
Springfield Hospital	$887,190	$1,699,848	2.3%	2.7%
SYSTEM	$33,093,814	$41,819,603	2.6%	1.6%

Free Care	ACT 00	BUD 07	ACT 00	BUD 07
Brattleboro Memorial Hospital	$786,624	$1,264,470	2.2%	1.8%
Central Vermont Hospital	$1,046,932	$1,375,000	1.2%	0.9%
Copley Hospital	$554,387	$884,624	1.8%	1.5%
Fletcher Allen Health Care	$9,707,703	$17,836,850	1.5%	1.3%
Gifford Memorial Hospital	$347,158	$872,564	1.1%	1.5%
Grace Cottage Hospital	$68,170	$113,990	1.0%	1.0%
Mt. Ascutney Hospital	$173,880	$701,818	0.7%	1.3%
North Country Hospital	$390,571	$725,985	0.9%	0.8%
Northeastern Vermont Regional Hos	$543,065	$1,075,000	1.4%	1.5%
Northwestern Medical Center	$669,500	$797,500	1.4%	1.0%
Porter Medical Center	$194,471	$716,659	0.5%	1.0%
Rutland Regional Medical Center	$1,099,800	$3,015,451	1.0%	1.2%
Southwestern Vermont Medical Cen	$511,228	$2,179,541	0.7%	1.5%
Springfield Hospital	$821,735	$1,637,854	2.2%	2.6%
SYSTEM	$16,915,225	$33,197,306	1.3%	1.3%

Appendix F

CALCULATING UNCOMPENSATED CARE COSTS

Combining bad debt and charity care (free care) to arrive at the hospital's total uncompensated care value allows for comparability across hospitals. There has been some shifting between bad debt and charity care because of the AICPA accounting changes over the years and because there are different policies at individual hospitals. However, this will not change the total reported cost of uncompensated care.

The total reported uncompensated care cost value can be calculated by applying each individual hospital's "cost to charge ratio" against the total gross billings (revenues) recorded for uncompensated care. After applying the ratio, we then sum the individual uncompensated care cost values across all hospitals.

Calculation

Bad Debt charges + charity care charges = Total uncompensated care charges

Total expenses (exclusive of bad debt)/Gross patient revenues = cost-to-charge ratio

Total uncompensated care charges x cost-to-charge ratio = Total uncompensated care costs

While the cost can be estimated in this manner, it is difficult, if not impossible to compare it across hospitals because the cost information is not reported in a manner that allows it to be connected to any specific set of services. For example, two hospitals could have the same number of events with the same total costs, but it is quite likely that the events will be made up of an entirely different set of services. One hospital could be providing acute inpatient care while another hospital could be providing a mix of both acute inpatient care and outpatient services. Therefore, it would not be useful to compare the information to determine whether one hospital had a higher cost structure.

The lack of this detailed information makes it difficult to not only compare costs, but to estimate the total costs that might be attributable to that population. This was most evident when BISHCA was trying to estimate costs for the Catamount Health Plan during the last session. The addition of new reporting requirements will help address the costs related to that population and allow us to better estimate funding or program needs related to various health plan designs.

Appendix G

MATRIX OF HOSPITALS FREE CARE STANDARDS

HOSPITAL NAME	Residence	100% Discounted	Sliding Scale Fee	Payment Forgiveness Criteria	Income verification	Asset verification
Brattleboro Memorial Hospital	No resident requirement.	300% of FPL Family of 1 < $29,400	All or nothing - 300%> of Fed. Poverty Guidelines, those who don't qualify, and no insurance, automatic 3% discount if patient pays within 30 days	Apply for Medicaid, Medicare, VA benefits, other Govt. Assistance	Complete Application, verification of income	List Assets on Application
Central Vermont Medical Center	CVMC Service Area - Washington & Orange counties	225% of FPL Family of 1 < $22,050	Sliding scale up to 350%; amount of bill, income	Apply for Medicaid, Medicare, VA benefits, other Govt. Assistance	Complete application with recent tax form, pay stub, income statements	Verify Bank Accounts, Real Estate, Stocks & Bonds
Copley Hospital	Vermont resident unless emergent care.	225% of FPL Family of 1 < $22,050	Sliding scale 225% to 300% FPL; income, family size	Patients may have other insurance which reimbursement will be sought first. If patient is uninsured, they are required to apply for VHAP.	Complete Application; proof of income	Monetary Assets maybe considered as a resource for payment
Fletcher Allen Health Care	FAHC service area including seven counties in New York and 3 counties in NH	300% of FPL Family of 1 < $29,550	None	Must have applied for all other possible forms of reimbursement	Application with requested supporting documentation.	Allowed assets of an amount equal to 300% of the VT Medical Assistance Resource Maximums, verification required
Gifford Memorial Hospital	Gifford Hospital Service Area unless urgent	225% of FPL Family of 1 < $22,050	267%=80% discount, 300%=70% discount	Must have applied for all other possible forms of reimbursement	Recent Income Statement, recent pay stubs, recent tax forms, proof of denial from other sources of assistance	Verify Bank Accounts, Real Estate, Stocks & Bonds
Grace Cottage Hospital	Local hospital service area.	100% of FPL Family of 1 < $9,800	Up to 200% of FPL, sliding scale	Must not have insurance or other government programs.	Application with requested supporting (income tax return) documentation.	N/A

HOSPITAL NAME	Residence	100% Discounted	Sliding Scale Fee	Payment Forgiveness Criteria	Income verification	Asset verification
Mt. Ascutney Hospital	Mt Ascutney Service Area	200% of FPL Family of 1 < $19,600	Sliding scale for < 300% of Fed. Poverty Guidelines	Must not have insurance or other government programs.	Application w/financial disclosure form	Net worth taken into consideration
North Country Hospital	U.S. citizen	200% of FPL Family of 1 < $19,600	No sliding scale at this time	applicants are asked to first apply for Medicaid programs.	Application with requested supporting (income) documentation.	Verification of Assets must be provided when requested
Northeastern Vermont Regional Hospital	Vermont or New Hampshire residence	200% of FPL Family of 1 < $19,600	Up to 300% of FPL, sliding scale	First apply for Medicaid or other government assistance	Application for Patient Assistance	N/A
Northwestern Medical Center	No resident requirement.	200% of FPL Family of 1 < $19,600	None at this time - being developed.	First apply for Medicaid or other government assistance	Financial questionnaire and proof of income	N/A
Porter Medical Center	No resident requirement.	200% of FPL Family of 1 < $19,600	Each case reviewed independently - no automatic adjustment.	Apply for Medicaid, Medicare, VA benefits, other Govt. Assistance. Complete application for free care.	Application for Free Care	Personal Financial Statement
Rutland Regional Medical Center	Local hospital service area.	200% of FPL Family of 1 < $19,600	Sliding scale up to 275% of FPL	all insurances must have been billed and paid to RRMC	Proof of income and family size	Net worth taken into consideration
Southwestern Vermont Medical Center	Local hospital service area.	200% of FPL Family of 1 < $19,600	Sliding scale from 200% to 300% of FPL	Must show proof of Medicaid denials.	Application with required supporting documentation, most recent tax returns	N/A
Springfield Hospital	Local hospital service area.	150% of FPL Family of 1 < $14,700	Sliding scale up to 150% of FPL	Apply for Medicaid, Previous Year Tax Return, 2 paystubs or SS benefits statement	Insurance Carrier, No. of Dependents, Occupation, Cash Assets, Income from all Family members	List Bank Accounts and Balances

FPL = Federal Poverty Level (or guidelines)